

General

Guideline Title

The role of endoscopy in the evaluation and management of dysphagia.

Bibliographic Source(s)

ASGE Standards of Practice Committee, Pasha SF, Acosta RD, Chandrasekhara V, Chathadi KV, Decker GA, Early DS, Evans JA, Fanelli RD, Fisher DA, Foley KQ, Fonkalsrud L, Hwang JH, Jue TL, Khashab MA, Lightdale JR, Muthusamy VR, Sharaf R, Saltzman JR, Shergill AK, Cash B. The role of endoscopy in the evaluation and management of dysphagia. *Gastrointest Endosc*. 2014 Feb;79(2):191-201. [148 references] [PubMed](#)

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Egan JV, Baron TH, Adler DG, Davila R, Faigel DO, Gan SL, Hirota WK, Leighton JA, Lichtenstein D, Qureshi WA, Rajan E, Shen B, Zuckerman MJ, Vanguilder T, Fanelli RD, Standards of Practice Committee. Esophageal dilation. *Gastrointest Endosc*. 2006 May;63(6):755-60. [72 references]

Recommendations

Major Recommendations

Definitions for the quality of the evidence (++++, +++O, ++OO, and +OOO) and for the strength of the recommendations ("recommends" or "suggests") are provided at the end of the "Major Recommendations" field.

1. The Practice Committee recommends endoscopic dilation for patients with dysphagia secondary to benign intrinsic strictures of the esophagus. (++++)
2. The Practice Committee recommends wire-guided dilation, preferably under fluoroscopic guidance, or through-the-scope (TTS) balloon dilation for complex esophageal strictures. (+++O)
3. The Practice Committee recommends antisecretory treatment in conjunction with dilation to reduce the recurrence rate of peptic strictures. (++++)
4. The Practice Committee recommends that dilation for adult patients with eosinophilic esophagitis (EoE) be reserved for those who have a dominant esophageal stricture or ring and those who remain symptomatic despite medical therapy. (+++O)
5. The Practice Committee suggests adjunctive treatment with corticosteroid injection into recurrent or refractory benign esophageal peptic strictures. (++OO)
6. The Practice Committee suggests that esophageal stent placement be reserved for refractory esophageal strictures that do not respond to sequential dilation and/or steroid injection. (++OO)
7. The Practice Committee recommends that both endoscopic and surgical treatment options for achalasia be discussed with the patient. In

patients who opt for endoscopic management and are good surgical candidates, the Practice Committee recommends pneumatic dilation with large-caliber balloon dilators for the endoscopic treatment of achalasia. (++++)

8. The Practice Committee recommends botulinum toxin injection for endoscopic treatment of achalasia in patients who are poor candidates for surgery or pneumatic dilation. (+++O)

Definitions:

Grading of Recommendations Assessment, Development and Evaluation (GRADE) System for Rating the Quality of Evidence for Guidelines

Quality of Evidence	Definition	Symbol
High quality	Further research is very unlikely to change confidence in the estimate of effect.	++++
Moderate quality	Further research is likely to have an important impact on confidence in the estimate of effect and may change the estimate.	+++O
Low quality	Further research is very likely to have an important impact on confidence in the estimate of effect and is likely to change the estimate.	++OO
Very low quality	Any estimate of effect is very uncertain.	+OOO

Adapted from Guyatt GH, Oxman AD, Vist GE, et al. GRADE: an emerging consensus on rating quality of evidence and strength of recommendations. BMJ 2008;336:924-6.

Recommendation Strength

The strength of individual recommendations is based on both the aggregate evidence quality and an assessment of the anticipated benefits and harms. Weaker recommendations are indicated by phrases such as "the Practice Committee suggests," whereas stronger recommendations are typically stated as "the Practice Committee recommends."

Clinical Algorithm(s)

None provided

Scope

Disease/Condition(s)

Esophageal dysphagia caused by benign or malignant conditions

Note: See Table 2 in the original guideline document for a list of common etiologies of esophageal dysphagia

Guideline Category

Evaluation

Management

Treatment

Clinical Specialty

Gastroenterology

Intended Users

Guideline Objective(s)

- To update the 2006 American Society for Gastrointestinal Endoscopy (ASGE) guidelines describing the role of endoscopy in the evaluation and management of dysphagia
- To provide information on the role of endoscopy in the evaluation and management of dysphagia

Target Population

Patients with esophageal dysphagia

Interventions and Practices Considered

1. Endoscopic dilation
2. Wire-guided dilation or through-the-scope (TTS) balloon dilation
3. Antisecretory treatment (in conjunction with dilation)
4. Adjunctive corticosteroid injection (into recurrent or refractory benign esophageal peptic strictures)
5. Esophageal stent placement (for refractory esophageal strictures that do not respond to sequential dilation and/or steroid injection)
6. Discussion of endoscopic and surgical treatment options for achalasia with the patient
7. Pneumatic dilation with large-caliber balloon dilators for endoscopic treatment of achalasia
8. Botulinum toxin injection (for patients who are poor candidates for surgery or pneumatic dilation)

Major Outcomes Considered

- Sensitivity, specificity, and accuracy of diagnostic tests
- Success rate of endoscopic procedures
- Incidence and severity of complications

Methodology

Methods Used to Collect/Select the Evidence

Hand-searches of Published Literature (Primary Sources)

Hand-searches of Published Literature (Secondary Sources)

Searches of Electronic Databases

Description of Methods Used to Collect/Select the Evidence

In preparing this guideline, a search of the medical literature was performed by using PubMed for the period 1990 to 2013. Additional references were obtained from the bibliographies of the identified articles and from recommendations of expert consultants. When few or no data exist from well-designed prospective trials, emphasis is given to results from large series and reports from recognized experts.

Number of Source Documents

Not stated

Methods Used to Assess the Quality and Strength of the Evidence

Weighting According to a Rating Scheme (Scheme Given)

Rating Scheme for the Strength of the Evidence

Grading of Recommendations Assessment, Development and Evaluation (GRADE) System for Rating the Quality of Evidence for Guidelines

Quality of Evidence	Definition	Symbol
High quality	Further research is very unlikely to change confidence in the estimate of effect.	++++
Moderate quality	Further research is likely to have an important impact on confidence in the estimate of effect and may change the estimate.	+++O
Low quality	Further research is very likely to have an important impact on confidence in the estimate of effect and is likely to change the estimate.	++OO
Very low quality	Any estimate of effect is very uncertain.	+OOO

Adapted from Guyatt GH, Oxman AD, Vist GE, et al. GRADE: an emerging consensus on rating quality of evidence and strength of recommendations. BMJ 2008;336:924-6.

Methods Used to Analyze the Evidence

Review of Published Meta-Analyses

Systematic Review

Description of the Methods Used to Analyze the Evidence

Not stated

Methods Used to Formulate the Recommendations

Expert Consensus

Description of Methods Used to Formulate the Recommendations

Guidelines for appropriate use of endoscopy are based on a critical review of the available data and expert consensus at the time that the guidelines are drafted.

Rating Scheme for the Strength of the Recommendations

Recommendation Strength

The strength of individual recommendations is based on both the aggregate evidence quality and an assessment of the anticipated benefits and harms. Weaker recommendations are indicated by phrases such as "the Practice Committee suggests," whereas stronger recommendations are typically stated as "the Practice Committee recommends."

Cost Analysis

- A cost analysis showed that esophagogastroduodenoscopy (EGD) with therapeutic intent is more cost-effective than an initial diagnostic approach with barium swallow in patients with histories suggestive of benign esophageal obstruction.

- Cost analysis models indicate that initial pneumatic dilation is a more cost-effective approach compared with botulinum toxin injection or laparoscopic Heller myotomy (LHM) for healthy patients with achalasia.

Method of Guideline Validation

Internal Peer Review

Description of Method of Guideline Validation

This document was reviewed and approved by the Governing Board of the American Society for Gastrointestinal Endoscopy (ASGE).

Evidence Supporting the Recommendations

Type of Evidence Supporting the Recommendations

The type of supporting evidence is identified and graded for each recommendation (see the "Major Recommendations" field).

Benefits/Harms of Implementing the Guideline Recommendations

Potential Benefits

Appropriate use of endoscopy as an effective tool in the evaluation and management of dysphagia

Potential Harms

- Dilation should be performed with caution in patients who have had a recent, healed perforation or upper gastrointestinal (GI) surgery.
- The main adverse events associated with dilation are perforation, bleeding, and aspiration. The perforation rate for esophageal strictures after dilation ranges from 0.1% to 0.4% and is higher with complex strictures and radiation-induced strictures. The perforation rate may be influenced by endoscopist experience.

Contraindications

Contraindications

The presence of an esophageal perforation is an absolute contraindication to esophageal dilation.

Qualifying Statements

Qualifying Statements

- Guidelines for appropriate use of endoscopy are based on a critical review of the available data and expert consensus at the time that the guidelines are drafted. Further controlled clinical studies may be needed to clarify aspects of this guideline. This guideline may be revised as necessary to account for changes in technology, new data, or other aspects of clinical practice.
- This guideline is intended to be an educational device to provide information that may assist endoscopists in providing care to patients. This guideline is not a rule and should not be construed as establishing a legal standard of care or as encouraging, advocating, requiring, or

discouraging any particular treatment. Clinical decisions in any particular case involve a complex analysis of the patient's condition and available courses of action. Therefore, clinical considerations may lead an endoscopist to take a course of action that varies from these guidelines.

Implementation of the Guideline

Description of Implementation Strategy

An implementation strategy was not provided.

Institute of Medicine (IOM) National Healthcare Quality Report Categories

IOM Care Need

Getting Better

Living with Illness

IOM Domain

Effectiveness

Identifying Information and Availability

Bibliographic Source(s)

ASGE Standards of Practice Committee, Pasha SF, Acosta RD, Chandrasekhara V, Chathadi KV, Decker GA, Early DS, Evans JA, Fanelli RD, Fisher DA, Foley KQ, Fonkalsrud L, Hwang JH, Jue TL, Khashab MA, Lightdale JR, Muthusamy VR, Sharaf R, Saltzman JR, Shergill AK, Cash B. The role of endoscopy in the evaluation and management of dysphagia. *Gastrointest Endosc*. 2014 Feb;79(2):191-201. [148 references] [PubMed](#)

Adaptation

Not applicable: The guideline was not adapted from another source.

Date Released

2006 May (revised 2014 Feb)

Guideline Developer(s)

American Society for Gastrointestinal Endoscopy - Medical Specialty Society

Source(s) of Funding

Guideline Committee

Standards of Practice Committee

Composition of Group That Authored the Guideline

Committee Members: Shabana F. Pasha, MD; Ruben D. Acosta, MD; Vinay Chandrasekhara, MD; Krishnavel V. Chathadi, MD; G. Anton Decker, MD; Dayna S. Early, MD; John A. Evans, MD; Robert D. Fanelli, MD, SAGES Representative; Deborah A. Fisher, MD; Kimberly Q. Foley, RN, BSN, CGRN, SGNA Representative; Lisa Fonkalsrud, RN, BSN, CGRN, SGNA Representative; Joo Ha Hwang, MD, PhD; Terry L. Jue, MD; Mouen A. Khashab, MD; Jenifer R. Lightdale, MD, MPH; V. Raman Muthusamy, MD; Ravi Sharaf, MD; John R. Saltzman, MD; Amandeep K. Shergill, MD; Brooks Cash, MD (*Chair*)

Financial Disclosures/Conflicts of Interest

The following authors disclosed financial relationships relevant to this publication: Dr Muthusamy, consultant to Boston Scientific; Dr Khashab, consultant to, honoraria from, and on the advisory board of Boston Scientific. All other authors disclosed no financial relationships relevant to this publication.

Guideline Status

This is the current release of the guideline.

This guideline updates a previous version: Egan JV, Baron TH, Adler DG, Davila R, Faigel DO, Gan SL, Hirota WK, Leighton JA, Lichtenstein D, Qureshi WA, Rajan E, Shen B, Zuckerman MJ, Vanguilder T, Fanelli RD, Standards of Practice Committee. Esophageal dilation. *Gastrointest Endosc.* 2006 May;63(6):755-60. [72 references]

Guideline Availability

Electronic copies: Available in Portable Document Format (PDF) from the [American Society for Gastrointestinal Endoscopy \(ASGE\) Web site](#)

Print copies: Available from the American Society for Gastrointestinal Endoscopy, 1520 Kensington Road, Suite 202, Oak Brook, IL 60523.

Availability of Companion Documents

None available

Patient Resources

None available

NGC Status

This NGC summary was completed by ECRI on June 7, 2006. This summary was updated by ECRI Institute on May 26, 2009, following the U.S. Food and Drug Administration advisory on Botox, Botox Cosmetic (Botulinum toxin Type A), and Myobloc (Botulinum toxin Type B). This summary was updated by ECRI Institute on August 17, 2009, following the updated FDA advisory on Botox and Botox Cosmetic (Botulinum toxin Type A), and Myobloc (Botulinum toxin Type B). This summary was updated by ECRI Institute on July 26, 2010 following the U.S. Food and Drug Administration (FDA) advisory on Proton Pump Inhibitors (PPI). The currency of the guideline was reaffirmed by the developer in 2011

and updated by ECRI Institute on November 3, 2011. This summary was updated by ECRI Institute on April 2, 2014.

Copyright Statement

This NGC summary is based on the original guideline, which is subject to the guideline developer's copyright restrictions.

Disclaimer

NGC Disclaimer

The National Guideline Clearinghouse^{â„¢} (NGC) does not develop, produce, approve, or endorse the guidelines represented on this site.

All guidelines summarized by NGC and hosted on our site are produced under the auspices of medical specialty societies, relevant professional associations, public or private organizations, other government agencies, health care organizations or plans, and similar entities.

Guidelines represented on the NGC Web site are submitted by guideline developers, and are screened solely to determine that they meet the [NGC Inclusion Criteria](#).

NGC, AHRQ, and its contractor ECRI Institute make no warranties concerning the content or clinical efficacy or effectiveness of the clinical practice guidelines and related materials represented on this site. Moreover, the views and opinions of developers or authors of guidelines represented on this site do not necessarily state or reflect those of NGC, AHRQ, or its contractor ECRI Institute, and inclusion or hosting of guidelines in NGC may not be used for advertising or commercial endorsement purposes.

Readers with questions regarding guideline content are directed to contact the guideline developer.